PRELIMINARY DRAFT

Workgroup II: Cardiovascular Disease

The second session of the Arkansas Healthcare Payment Improvement Initiative Cardiovascular Disease Workgroup convened on December 6, 2011 to discuss payment innovation in Arkansas, with an emphasis on episode-based payment for cardiovascular disease. The second workgroup remained focused on congestive heart failure (CHF).

Approximately 50 Arkansas healthcare professionals and patients were in attendance at the first workgroup, representing perspectives of providers (cardiologists, cardiac surgeons, internists, family medicine physicians, pharmacists, nurses), hospital leaders, advocacy groups, public health experts, nonprofit administrators, government officials, and others.

Workgroup materials and an overview of the payment model can be accessed online at < http://humanservices.arkansas.gov/director/Pages/Cardiovascular-Disease-Workgroup.aspx>. Key components of the discussion are summarized below.

KEY COMPONENTS OF WORKGROUP II DISCUSSION

- The second workgroup session focused on:
  - Reviewing the principles and preferred payment structure for administering episode-based payment
  - Discussing the appropriate boundaries of a congestive heart failure episode
  - Discussing a conceptual approach to ensuring quality of care through episode-based payment
- The workgroup discussed the range of options for episode-based payment, with an emphasis on the episode-based retrospective reconciliation model in which the primary accountable provider(s) share in the difference between the episode target price and total accrued cost of care.
- Workgroup members provided input on the approach to payment innovation:
  - Workgroup participants raised the question of whether or not payments would include a regional adjustment or adjustment for critical access hospitals. Participants also underscored the importance of discussing plan for risk adjustment in future workgroups, including the question of whether Stage D patients should be treated differently.
  - Given the use of the fee-for-service chassis for payments, some participants asked how services not currently reimbursed under fee-for-service would be included. Future workgroups will explore further, along with the question or which providers will qualify as "accountable providers."

- Participants highlighted the importance of encouraging innovation under the new payment model. Innovation is constrained in the current payment system because only certain activities are reimbursed. Under an episode-based payment, a care provider could choose to spend time on activities that he or she believed would improve patient outcomes (e.g., time on patient education, emailing with patients) and could be compensated through gain-sharing.
- Likewise, workgroup participants commented that the pharmacist network is underused as a resource in a patient's global care, particularly in rural areas that may have access to few other providers. Participants suggested the payment model may provide incentives for collaboration.
- Workgroup members highlighted the importance of data transparency for providers to understand their own results and continuously improve.

- The workgroup discussed a proposal to divide congestive heart failure care into two component episodes: a chronic, 12 month CHF episode, and an acute/post-acute episode. The chronic episode will be addressed through a population-based model (e.g., medical home); the acute/post-acute episode will be the initial focus for episodic payment.
- The goals of the acute/post-acute episode will be to stabilize and admission and reintegrate the patient into chronic care. The episode may include all hospital facility fees, inpatient professional fees, rehabilitation facility fees, home health, and any readmissions within a certain period (e.g., 45 days).
- Workgroup members provided input on the episode boundaries:
  - Some participants felt that preventing readmissions through use of heart failure clinics run by APNs could be very cost effective under model. Because the episode payment will likely price in an expected rate of readmissions, providers who can beat these targets with investments in more cost-effective, preventive care like heart failure clinics will be rewarded under the model.
  - Workgroup members noted that there is a blurred line between where a post-acute episode ends and a chronic episode begins. Members also suggested that design should maximize cross-provider communication; if a hospital were the accountable provider, for instance, it would be sub-optimal for the hospital to merely extend the time period in which they direct the patient's care without reintegrating into chronic care.
  - Participants cautioned that there is not a sharp line between an avoidable and unavoidable readmission. Studies show that a portion of readmissions are planned and intended as the next step in the patient's care. All participants agreed that the readmission target should not be set at 0%; the group also agreed that avoiding certain readmissions is in the best interest of the patient and the system overall.
- The workgroup discussed the importance of ensuring that high-quality care is delivered under an episode-based payment. The episode model inherently rewards

providers for quality care in many areas, but the group also will need to assess whether there are areas providers could be incentivized to provide inadequate care and to address in model design. Further discussion on this topic was deferred to the next workgroup due to time limitations.